

**Peepers Optical
New Patient Questionnaire**

Date _____

Last Name _____ First Name _____ MI _____
Address _____
City _____ State _____ Zip _____
DOB _____ SSN _____ - _____ - _____ Email _____
Home phone _____ Cell phone _____ Work phone _____
Employer _____ Occupation _____
How did you hear about our office? _____

Vision/Eye Insurance Information
(circle one)

VSP Eyemed/ BlueView Vision Superior Spectera Other _____

Medical Insurance Information
(circle one)

United Health Care Cigna Aetna Rocky Mountain Health BC/BS Anthem PacifiCare

Other _____

What is the reason for your visit today? _____

Are you experiencing any of the following symptoms? (circle all that apply)

Blurred vision at distance or near (circle which) Dry eyes Eye pain Light sensitivity Headaches
Eye strain (when?) _____ Red eyes Eyes hurt or tired Frequent styes Watery eyes
Burning eyes Holding reading close Flashes Floaters Crossed or wandering eye Itchy eyes
Double Vision Poor night vision Sandy/gritty eyes

If you wear glasses or contacts, are you experiencing any of the symptoms with your prescription on? Yes No

Visual History:

Approximate date/year of last vision exam: _____

Do you wear glasses? Yes No If yes, full time? Yes No Near Only Distance Only

Do you wear contacts? Yes No If yes, are you happy with your vision? Yes No Comfort? Yes No

How often do you change each pair? _____ Do you sleep in your contacts? Yes No

If yes, how often? _____

Brand currently wearing _____

Type of contact lenses: (circle one) Rigid Gas Perm Multifocal Toric Soft – extended wear or daily?

Have you ever had any of the following (please detail):

Eye diseases _____ Eye injuries _____

Eye surgery _____ Other _____

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Personal Medical History

How would you describe your current health?

_____ Excellent _____ Good _____ Fair _____ Poor

Do you have any of these medical conditions? (circle all that apply)

Thyroid Diabetes High Cholesterol Cardiac High Blood Pressure
Depression/Anxiety HIV Auto Immune Disease Cancer None

What medications are you currently taking? (Include supplements) _____

Do you have any medication/general allergies? Yes No

If yes, please specify _____

Are you pregnant? Yes No If yes, due date? _____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substances? _____

Family Medical History

Mark conditions that run in your family

- | | | | |
|--------------------------|----------------------|--------------|-------|
| <input type="checkbox"/> | Blindness | Relationship | _____ |
| <input type="checkbox"/> | Cataracts | Relationship | _____ |
| <input type="checkbox"/> | Color Blind | Relationship | _____ |
| <input type="checkbox"/> | Lazy Eye | Relationship | _____ |
| <input type="checkbox"/> | Allergies | Relationship | _____ |
| <input type="checkbox"/> | Arthritis | Relationship | _____ |
| <input type="checkbox"/> | Cancer | Relationship | _____ |
| <input type="checkbox"/> | Glaucoma | Relationship | _____ |
| <input type="checkbox"/> | Diabetes | Relationship | _____ |
| <input type="checkbox"/> | Thyroid | Relationship | _____ |
| <input type="checkbox"/> | Heart Disease | Relationship | _____ |
| <input type="checkbox"/> | High Blood Pressure | Relationship | _____ |
| <input type="checkbox"/> | Macular Degeneration | Relationship | _____ |
| <input type="checkbox"/> | Retinal Detachment | Relationship | _____ |
| <input type="checkbox"/> | Blood Diseases | Relationship | _____ |
| <input type="checkbox"/> | Other | Relationship | _____ |

Lifestyle Questions: (check all that apply)

Computer Use If yes, how many hours per day? _____ Do you use a Blackberry or a PDA for work? Yes No

- Skiing/Boarding
- Racquet Sports
- Running
- Fishing
- Woodwork
- Basketball
- Volleyball
- Hunting
- Motocycling
- Golf
- Hiking

Are you interested in information on vitamin supplements to improve your eye health? Y N

Thank you for choosing Peepers Optical for all your optical needs